

GUIDELINE FOR IMPLEMENTATION OF MEDICAL PROFESSIONAL LIABILITY CLOSED CLAIM REPORTING

PART A SUGGESTED REGULATION ON REPORTING REQUIREMENTS

Table of Contents

Section 1.	Statement of Purpose
Section 2.	Definitions
Section 3.	Applicability and Scope
Section 4.	Claims Required to Be Reported
Section 5.	Assignment of Claim and Incident Identifiers
Section 6.	Responsibility for Reporting Data
Section 7.	Reporting of Specific Data Elements

Section 1. Statement of Purpose

This regulation establishes detailed reporting requirements that are consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*.

Section 2. Definitions

As used in this regulation:

- A. "Claim" means the same as in subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- B. "Claim identifier" means the unique alphanumeric sequence assigned to a claim by the reporting entity as required by subsection 5A(1) of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- C. "Claimant" means the same as in subsection 2B of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- D. "Closed claim" means the same as in subsection 2C of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- E. "Commissioner" means the same as in subsection 2D of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- F. "Companion claims" means the same as in subsection 2E of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- G. "Defense and cost containment expenses" means expenses paid or incurred for defense, litigation and cost containment services. The amounts reported for an insuring entity's or self-insurer's employees should include overhead, just as an outside firm's charges would include.
 - (1) Defense and cost containment expenses include:

- (a) Surveillance expenses;
 - (b) Fixed amounts for cost containment expenses;
 - (c) Litigation management expenses;
 - (d) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in defense of a claim, and fees or salaries for rehabilitation nurses, if such cost is not included in losses;
 - (e) Attorney fees incurred owing to a duty to defend, even when other coverage does not exist; and
 - (f) The cost of engaging experts.
- (2) Defense and cost containment expenses do not include:
- (a) Fees of adjusters and settling agents (but not if engaged in a contentious defense);
 - (b) Attorney fees incurred in the determination of coverage, including litigation between the insuring entity and the policyholder; and
 - (c) Fees or salaries for appraisers, private investigators, hearing representatives, reinspectors and fraud investigators, if working in the capacity of an adjuster.
- H. “Economic damages” means the same as in subsection 2F of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- I. “Excess insuring entity” means an insuring entity that provides insurance coverage above the limits of primary insurance or a self-insured retention.
- J. “Facility” means the same as in subsection 2G of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- K. “Incident” means an alleged medical error or omission or a series of related errors or omissions leading to allegations of harm. A single incident may span multiple years and involve numerous named defendants.
- L. “Incident identifier” means the unique alphanumeric sequence assigned by the reporting entity to a series of closed claims that result from a single incident or related series of incidents of medical malpractice, as required by subsection 5A(2) of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- M. “Insuring entity” means the same as in subsection 2I of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- N. “Medical malpractice” means the same as in subsection 2J of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- O. “Noneconomic damages” means the same as in subsection 2K of the *Medical Professional Liability Closed Claim Reporting Model Law*.

- P. “Primary insuring entity” means the insuring entity that originates the primary layer of insurance coverage. A self-insurer is not considered to be a primary insuring entity.
- Q. “Provider” means the same as in subsection 2H of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- R. “Reporting entity” means any person or entity required to report data under Section 4 of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- S. “Self-insurer” means the same as in subsection 2L of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- T. “User ID” is a permanent alphanumeric sequence assigned by the commissioner to each insuring entity, self-insurer, facility or provider that reports data.

Section 3. Applicability and Scope

This regulation is intended to implement this state’s medical professional liability closed claim reporting requirements in a manner that is consistent with the NAIC *Medical Professional Liability Closed Claim Reporting Model Law*. It applies to all reporting entities as defined in subsection 2R of this regulation.

Section 4. Claims Required to Be Reported

- A. The types of closed medical professional liability claims that must be reported to the commissioner include:
 - (1) Claims closed with an indemnity payment;
 - (2) Claims closed with paid defense and cost containment expenses; and
 - (3) Claims closed with both indemnity payments and paid defense and cost containment expenses.
- B. If a self-insurer, facility or provider waives copayments, forgives bills or deductibles, or makes other similar accommodations to a client, it is not a claim under subsection 2A of the *Medical Professional Liability Closed Claim Reporting Model Law*. Reporting entities are not required to report these types of accommodations to the commissioner.
- C. A claim is closed on the date the reporting entity takes final administrative action to close the claim. Final administrative action occurs after the reporting entity:
 - (1) Issues the final payment to the claimant in the form of a check, draft, or electronic funds transfer;
 - (2) Pays all outstanding bills for defense and cost containment expenses; and
 - (3) If applicable, receives all indemnity and defense and cost containment expense payment data needed for reporting from a facility, provider or excess insuring entity.
- D. If a closed claim is reopened to update data, the reporting entity must report the updated data to the commissioner after it updates and closes the claim file.

Section 5. Assignment of Claim and Incident Identifiers

- A. The reporting entity must assign a different claim identifier to each closed claim report.

- (1) The commissioner will combine the reporting entity's user ID with the claim identifier to create a unique record identifier for each claim.
 - (2) The commissioner may use the record identifier to trace the claim for auditing purposes.
- B. If a claimant makes claims against more than one facility or provider insured by an insuring entity or self-insurer, the insuring entity or self-insurer must report each claim separately and include an incident identifier.

Section 6. Responsibility for Reporting Data

- A. Except as provided by subsections B through F of this section, primary insuring entities are principally responsible for reporting closed claim data required under the *Medical Professional Liability Closed Claim Reporting Model Law*.
- (1) The primary insuring entity must report the total amounts paid to settle the claim, including any indemnity or defense and cost containment expense payments made by:
 - (a) An insured facility or provider;
 - (b) An excess insuring entity; or
 - (c) Any other person or entity on behalf of the facility or provider.
 - (2) Facilities or providers insured by the primary insuring entity must cooperate and assist the primary insuring entity in the reporting process.
 - (3) If a primary insuring entity and one or more excess insuring entities combine to pay a claim:
 - (a) The primary insuring entity must report all paid indemnity and defense and cost containment expenses; and
 - (b) The excess insuring entity must cooperate and assist the primary insuring entity in the reporting process.
- B. If an excess insuring entity insures a self-insurer and makes indemnity payments or incurs defense and cost containment expenses, the excess insuring entity is principally responsible to report the required closed claim data.
- (1) Self-insurers must report all claim payments and defense and cost containment expenses to the excess insuring entity for reporting purposes; and
 - (2) The excess insuring entity must report data on behalf of itself and the self-insurer.
 - (3) An excess insuring entity is not responsible to report closed claim data reported by a primary insuring entity under subsection 6A of this Guideline.
- C. If a closed claim payment falls wholly within its self-insured retention, the self-insurer must report the required closed claim data.

- D. A self-insurer may designate itself to be the principal reporting entity and report closed claim data on behalf of itself and any excess insuring entity. If the self-insurer designates itself to be the principal reporting entity, the self-insurer must:
- (1) Notify the commissioner in writing of this arrangement;
 - (2) Report the required closed claim data on behalf of itself and the excess insuring entity; and
 - (3) Accept responsibility for compliance with the requirements of subsection 4A of the *Medical Professional Liability Closed Claim Reporting Model Law*.
- E. A facility or provider is responsible to report the required closed claim data if:
- (1) There is no insurance coverage available from an insuring entity or self-insurer to defend or pay the claim; or
 - (2) The insuring entity or self-insurer fails to report the required closed claim data.
- F. An insuring entity or self-insurer may designate a third party to report closed claim data. In this case the insuring entity or self-insurer must:
- (1) Obtain a user ID from the commissioner;
 - (2) Designate the third party as the entity that will report closed claim data on its behalf;
 - (3) Manage the activities of the third party with respect to the insuring entity's or self-insurer's closed claim data; and
 - (4) Retain responsibility for all closed claim data submitted by the third party.

Section 7. Reporting of Specific Data Elements

- A. Policy limits—When reporting the policy limits of the medical professional liability insurance policy covering the claim, reporting entities must report the following, if applicable:
- (1) Primary policy limit, per occurrence (a self-insured retention is not a primary policy limit);
 - (2) Annual limit of primary policy;
 - (3) Excess policy limit, per occurrence;
 - (4) Annual limit of excess policy; Deleted: and
 - (5) Available primary policy limit; and
 - (6) Available excess policy limit; Deleted: s.
- B. Medical specialty—When reporting medical specialties, reporting entities must use the *Field of Licensure Codes* and *Medical Specialty Codes* published by the National Practitioner Data Bank.

- C. Type of health care facility—When reporting the type of health care facility, the reporting entity must use the *Type of Organization Codes* published by the National Practitioner Data Bank (NPDB). Public facilities, such as prisons and universities, must review the NPDB *Type of Organization Codes* and enter the most similar classification.
- D. Primary location within a facility—When reporting the primary location within a facility where the incident occurred, the reporting entity must use the incident locations published by the Physician Insurers Association of America in conjunction with its data-sharing project. The reporting entity must report one of these locations:
- (1) Catheterization lab;
 - (2) Critical care unit;
 - (3) Dispensary;
 - (4) Emergency department;
 - (5) Labor and delivery room;
 - (6) Laboratory;
 - (7) Nursery;
 - (8) Operating room;
 - (9) Outpatient department;
 - (10) Patient room;
 - (11) Pharmacy;
 - (12) Physical therapy department;
 - (13) Radiation therapy department;
 - (14) Radiology department;
 - (15) Recovery room;
 - (16) Rehabilitation center;
 - (17) Special procedure room;
 - (18) Location other than an inpatient facility:
 - (a) Clinical support center, such as a laboratory or radiology center;
 - (b) Office;
 - (c) Walk-in clinic; or
 - (d) Other;
 - (19) Other department in hospital;

(20) Unknown; and

(21) Other.

E. County—When reporting the county in which the incident occurred, the reporting entity must report based on the location of the facility where the incident occurred. If more than one alleged medical error led to the claim, the reporting entity must choose the location where the alleged medical error leading most directly to the injury occurred. In the event that an alleged medical error occurs outside this state, but the claim is made in this state, a closed claim report must be filed in this state and the county shown as “Location out of state.”

F. Severity of injury—When reporting the severity of injury, the reporting entity must use the National Practitioner Data Bank severity scale. This scale shows the medical outcome for temporary and permanent injuries.

(1) Temporary injuries include:

- (a) Emotional injury only, such as fright, where no physical damage occurred;
- (b) Insignificant injury, such as lacerations, contusions, minor scars or rash, where no delay in recovery occurs;
- (c) Minor injury, such as infection, fracture set improperly or a fall in the hospital, where recovery is complete but delayed; and
- (d) Major injury, such as burns, surgical material left, drug side effect or brain damage, where recovery is complete but delayed.

(2) Permanent injuries include:

- (a) Minor injury, such as loss of fingers or loss or damage to organs, where the injury is not disabling;
- (b) Significant injury, such as deafness, loss of limb, loss of eye or loss of one kidney or lung;
- (c) Major injury, such as paraplegia, blindness, loss of two limbs or brain damage;
- (d) Grave injury, such as quadriplegia, severe brain damage, life-long care or fatal prognosis; and
- (e) Death.

(3) If several injuries are involved, the reporting entity should report the most severe injury.

G. Dates—All dates required by subsection 51 of the *Medical Professional Liability Closed Claim Reporting Model Law* must be reported. When reporting the date of notice to the insuring entity, self-insurer, facility or provider, the reporting entity must report the date on which:

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(1) The insured notifies the primary insuring entity or self-insurer of a claim if insurance coverage is available; or

- (2) The claimant notifies the facility or provider of a claim if insurance coverage is not available.
- H. Claim disposition—When reporting the method of claim disposition, the reporting entity must describe the method of claim disposition using one of the following descriptions:
- (1) Claim is abandoned by the claimant.
 - (2) Claim is settled by the parties.
 - (3) Claim is disposed of by a court when the court issues a:
 - (a) Directed verdict for the plaintiff;
 - (b) Directed verdict for the defendant;
 - (c) Judgment notwithstanding verdict for the plaintiff (judgment for the defendant);
 - (d) Judgment notwithstanding verdict for the defendant (judgment for the plaintiff);
 - (e) Involuntary dismissal;
 - (f) Judgment for the plaintiff;
 - (g) Judgment for the defendant;
 - (h) Judgment for the plaintiff after appeal; or
 - (i) Judgment for the defendant after appeal.
 - (4) Claim is settled by an alternative dispute resolution process, whether resolved by:
 - (a) Arbitration;
 - (b) Mediation;
 - (c) Private judging or private trial; or
 - (d) Other type of alternative dispute resolution process.
- I. Timing of disposition—When reporting the timing of the claim disposition, the reporting entity must report whether the claim is settled:
- (1) Before requesting arbitration, mediation, or private trial;
 - (2) Before trial, arbitration or mediation;
 - (3) During trial, arbitration or mediation;
 - (4) After trial or hearing, but before judgment or award;
 - (5) After judgment or decision, but before appeal;

- (6) During an appeal;
- (7) After an appeal; or
- (8) During review panel or non-binding arbitration.

J. Indemnity payments and defense and cost containment expenses;

- (1) When reporting indemnity payments, the reporting entity must report payments on a gross basis and provide the total amount paid to the claimant to settle the claim. The reporting entity must not deduct the value of offsets or recoverables, such as:
 - (a) Reimbursement by the insured for a deductible;
 - (b) Reimbursement by a reinsurer or excess insuring entity; or
 - (c) Anticipated subrogation recoveries.
- (2) When indemnity payments exceed the facility's or provider's policy limits, the reporting entity must report the total amount paid by all parties on behalf of the insured, including:
 - (a) The amount paid by all the insuring entities. The actual amount paid may be higher or lower than the policy limit, depending on the settlement agreement.
 - (b) Additional payments in excess of policy limits made by the insured facility or provider to the claimant.
- (3) Subrogation between insuring entities or self-insurers may occur if there is a dispute over which entity should respond to a lawsuit. If an insuring entity or self-insurer receives a subrogation payment, it must report subrogation proceeds and any defense and cost containment expenses paid to obtain those proceeds. If necessary, the reporting entity may reopen the claim to report this information.
- (4) Structured settlements:
 - (a) If a claim is paid with a structured settlement agreement, the reporting entity must report the lump-sum payment for the purchase of the annuity.
 - (b) If a claim is paid with a combination of a lump-sum payment to the claimant and a structured settlement, the reporting entity must report the sum of both payments.
- (5) If more than one claim is filed with a reporting entity due to an incident of medical malpractice, the reporting entity must report companion claim payments in this manner:
 - (a) Indemnity payments and defense and cost containment expenses paid to defend and settle each claim must be reported separately for each facility or provider.

- (b) If indemnity payments are based on a trial verdict, the reporting entity must use the apportionment resulting from the verdict.
 - (c) If indemnity payments are not based on a trial verdict, the reporting entity must allocate indemnity payments among facilities and providers based on an assessment of comparative fault.
 - (d) The reporting entity must allocate defense and cost containment expense payments based on the extent to which each facility or provider benefited from the defense services.
 - (e) The reporting entity is responsible for assigning incident identifiers only for its own claims.
- (6) When reporting defense and cost containment expenses, the reporting entity must report:
- (a) Defense and cost containment expenses paid for defense counsel, including both in-house and outside counsel;
 - (b) Defense and cost containment expenses paid for experts, including both in-house and outside experts;
 - (c) All other defense and cost containment expenses; and
 - (d) Total defense and cost containment expenses.
- (7) When an insuring entity or self-insurer uses company employees, including professional medical staff and in-house legal counsel, to defend claims, the reporting entity:
- (a) Must include in defense and cost containment expenses the salary, benefits and an allocation of overhead for those employees; and
 - (b) May use average salaries and the results of time studies when calculating these defense and cost containment expenses.

K. Estimation of economic and noneconomic damages:

- (1) If indemnity payments are the amounts awarded by a court for economic and noneconomic damages, respectively, the reporting entity must report those amounts.
- (2) Otherwise, if a reporting entity makes indemnity payments to a claimant, the reporting entity must report the portion of the indemnity payments related to economic damages and the portion of the indemnity payments related to noneconomic damages based on documented evidence obtained during the claim resolution process. Reporting entities may not determine these amounts using a fixed formula, such as fifty percent of total paid indemnity.
- (3) The total indemnity payments must be equal to the sum of the reporting entity's best estimate of indemnity payments related to economic damages and the reporting entity's best estimate of indemnity payments related to noneconomic damages, and neither estimate may exceed the total indemnity payment.